Chapter 3: Using our plan’s coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you’re billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

[*Plans should refer to other parts of the Evidence of Coverage using the appropriate chapter number and section as appropriate. For example, "refer to* ***Chapter 9****, Section A." An instruction* [*insert reference, as applicable*] *appears with many cross references throughout the Evidence of Coverage. Plans can always include additional references to other sections, chapters, and/or member materials when helpful to the reader.*]

[*Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.*]

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# Information about services and providers

**Services** are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this *Evidence of Coverage*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Evidence of Coverage*.

**Providers** are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

**Network providers** are providers who work with our plan. These providers agree to accept our payment which includes cost sharing as full payment. [*Plans can delete the next sentence if it isn’t applicable*.] We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay [*nothing or only your share of the cost*] for covered services.

# Rules for getting services our plan covers

Our plan covers all services covered by Medicare and TennCare. This includes behavioral health and LTSS.

Our plan will generally pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

* The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.
* The care must be **medically necessary**.By medically necessary, wemean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
* [*Plans can omit or edit the PCP-related bullets as necessary, including modifying the name of the PCP*.] For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (for more information, go to **Section D1** of this chapter).
  + In most cases, [*insert as applicable:* your network PCP or our plan] must give you approval before you can use a provider that isn’t your PCP or use other providers in our plan’s network. This is called a **referral**. If you don’t get approval, we may not cover the services.
* [*Insert if applicable:* Our plan’s PCPs are affiliated with medical groups. When you choose your PCP, you’re also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is <definition>.]
  + You don’t need referrals from your PCP for emergency care or urgently needed care or to use a woman’s health provider. You can get other kinds of care without having a referral from your PCP (for more information, go to **Section D1** in this chapter).
* [*Plans with a POS option can edit the network provider bullets as necessary.*]**You must get your care from network providers** (for more information, go to **Section D** in this chapter). Usually, we won’t cover care from a provider who doesn’t work with our health plan. This means that you’ll have to pay the provider in full for services you get. Here are some cases when this rule doesn’t apply:
  + We cover emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I** in this chapter).
  + If you need care from a Specialist that our plan covers and our network providers can’t give it to you, you can get care from an out-of-network provider. You MUST get prior approval for these services. In this situation, we cover the care as if you got it from a network provider at no additional cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.
  + We cover kidney dialysis services when you’re outside our plan’s service area for a short time or when your provider is temporarily unavailable or not accessible. [*Insert as applicable:* The cost-sharing you pay for dialysis can never be higher than the cost-sharing in Original Medicare. If you’re outside our plan’s service area and get dialysis from a provider outside the plan’s network, your cost-sharing can’t be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from an out-of-network provider your cost-sharing for the dialysis may be higher*.* If possible, call Member Services at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you’re away.]
  + If you were already getting care or treatment when your TennCare started, you may be able to keep getting the care without an approval or referral.

# Your care coordinator

We’re responsible for managing all of your physical health, behavioral health (mental health or substance use disorder) and long-term services and supports needs, and the services that you receive to address these needs. This is called care coordination. We’ll assign you a care coordinator when you enroll in our plan.

## C1. What’s a care coordinator

Your care coordinator will play a very important role. Your care coordinator is your primary contact person and is the first person that you should go to if you have any questions about your services. Your care coordinator will:

* Provide information about your coverage and answer your questions.
* Help you get the right kind of long-term services and supports in the right setting for you to address your needs.
* Coordinate all of your physical health, behavioral health (mental health or substance use disorder) and long-term services and supports needs.
* Help to fix problems and answer questions that you have about your care.
* Check at least once a year to make sure that you continue to need the level of care provided in a nursing home or, for Group 3, continue to be “at risk” of going into a nursing home.
* Communicate with your providers to make sure they know what’s happening with your health care and to coordinate your service delivery.

## C2. How you can contact your care coordinator

[*Plan must include instructions for contacting a care coordinator*.]

## C3. How you can change your care coordinator

[*Plan must include instructions for how to change a care coordinator*.]

# Care from providers

## D1. Care from a primary care provider (PCP)

[*Insert if applicable and adjust language to describe PCP requirements:* You must choose a PCP to provide and manage your care. Our plan’s PCPs are affiliated with medical groups. When you choose your PCP, you’re also choosing the affiliated medical group.]

**Definition of a PCP and what a PCP does do for you**

[*Plans describe the following in the context of their plans:*

What’s a PCP

If applicable, what’s a medical group or IPA

What types of providers may act as a PCP[*If a State allows specialists to act as a PCP, plans must inform members of this and under what circumstances a specialist may be a PCP.*]

The role of a PCP in

* coordinating covered services
* making decisions about or getting a coverage decision, if applicable

When a clinic can be your PCP (RHC/FQHC)]

**Your choice of PCP**

[*Plans describe how to choose a PCP. Plans that assign members to medical groups or IPAs must include language that explains how the choice of PCP will affect member access to specialists and hospitals. For example:* If there’s a particular specialist or hospital that you want to use, find out if they’re affiliated with your PCP’s medical group. You can look in the Provider and Pharmacy Directory or ask Member Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.]

**Option to change your PCP**

You can change your PCP for any reason, at any time. It’s also possible that your PCP may leave our plan’s network. If your PCP leaves our network, we can help you find a new PCP in our network.

[*Plans describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.)*.]

[*Insert if applicable:* Our plan’s PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Member Services if you use a specialist or get other covered services that must have PCP approval. Member Services helps you continue your specialty care and other services when you change your PCP.]

**Services you can get without approval from your PCP**

[***Note:*** *Insert this section only if plans require referrals to network providers*.]

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

* Emergency services from network providers or out-of-network providers.
* Urgently needed covered services that require immediate medical attention (but not an emergency) if you’re either temporarily outside our plan’s service area, or if it’s unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren’t considered urgently needed even if you’re outside our plan’s service area or our network is temporarily unavailable.
* Kidney dialysis services that you get at a Medicare-certified dialysis facility when you’re outside our plan’s service area. Call Member Services before you leave the service area. We can help you get dialysis while you’re away.
* Flu shots and COVID-19 vaccines [*insert if applicable:* as well as hepatitis B vaccines and pneumonia vaccines] [*insert if applicable*: as long as you get them from a network provider].
* Routine women’s health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams [*insert if applicable*: as long as you get them from a network provider].
* Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.

[*Plans add additional bullets consistently formatted like the rest of this section as appropriate*.]

## D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

* Oncologists care for patients with cancer.
* Cardiologists care for patients with heart problems.
* Orthopedists care for patients with bone, joint, or muscle problems.

[*Plans must describe how members access specialists and other network providers, including:*

*The role (if any) of the PCP in referring members to specialists and other providers.*

*A description of PA as well as the process for getting PA. Plans should explain that PA means the member gets plan approval before getting a specific service or drug or using an out-of-network provider, and plans include information about who makes the PA decision (e.g., Medical Director, the PCP, or another entity). Refer members to Chapter 4 for information about which services require PA.*

*If the PCP selection results in being limited to specific specialists or hospitals to which that PCP refers* *For example, plans should include information about subnetworks if applicable.*]

## D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:

* Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
* We’ll notify you that your provider is leaving our plan so that you have time to select a new provider.
  + If your primary care or behavioral health provider leaves our plan, we’ll notify you if you visited that provider within the past three years.
  + If any of your other providers leave our plan, we’ll notify you if you’re assigned to the provider, currently get care from them, or visited them within the past three months.
* We help you select a new qualified in-network provider to continue managing your health care needs.
* If you’re currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies you’re getting continues. We’ll work with you so you can continue to get care.
* We’ll give you information about the available periods and options you may have for changing plans.
* If we can’t find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. [*Plans should indicate if prior authorization is needed*.]
* If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider and to manage your care.
* If you think we haven’t replaced your previous provider with a qualified provider or that we aren’t managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** [*plans can insert reference, as applicable*] for more information.)

## D4. Out-of-network providers

[*Plans tell members under what circumstances they can get services from out-of-network providers (e.g., when providers of specialized services aren’t available in network). Include Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it*.] [*Note: Members are entitled to get services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for ESRD members who have traveled outside the plans service area or when the provider is temporarily unavailable or not accessible and aren’t able to access contracted ESRD providers.*]

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or TennCare.

* We can’t pay a provider who isn’t eligible to participate in Medicare and/or TennCare.
* If you use a provider who isn’t eligible to participate in Medicare, you must pay the full cost of the services you get.
* Providers must tell you if they aren’t eligible to participate in Medicare.

# Long-term services and supports (LTSS)

TennCare CHOICES is Long-Term Services and Supports (or CHOICES for short) for adults (age 21 and older) with a physical disability and seniors (age 65 and older). CHOICES offers services to help a person live in their own home or in the community. These services are called **H**ome and **C**ommunity **B**ased **S**ervices or HCBS. These services can be provided in the home, on the job, or in the community to assist with daily living activities and allow people to work and be actively involved in their local community. CHOICES also provides care in a nursing home if it’s needed.

## E1. How do I apply for CHOICES?

If you think you need long-term services and supports, call us at <phone number>**.** We may use a short screening that will be done over the phone to help decide if you may qualify for CHOICES. If the screening shows that you don’t appear to qualify for CHOICES, you’ll get a letter that says how you can finish applying for CHOICES.

If the screening shows that you might qualify for CHOICES, or if we don’t conduct a screening over the phone, we’ll send a care coordinator to your home to do an assessment.

The purpose of the in-home assessment is to help you apply for CHOICES. It’s also to find out:

* The kinds of help you need;
* the kinds of care being provided by family members and other caregivers to help meet your needs; **and**
* the gaps in care for which paid long-term services and supports may be needed.

If you want to receive care at home or in the community (instead of going to a nursing home), the assessment will help decide if your needs can be safely met in the home or community setting. For CHOICES Group 2 (you can read about all of the CHOICES Groups below), it will help decide if the cost of your care would exceed the cost of nursing home care.

This **doesn’t** mean that you’ll receive services up to the cost of nursing home care. CHOICES won’t pay for more services than you must have to safely meet your needs at home. And CHOICES only pays for services to meet long-term services and supports needs that can’t be met in other ways.

CHOICES services provided to you in your home or in the community won’t take the place of care you get from family and friends or services you already receive.

If you’re getting help from community programs, receive services paid for by Medicare or other insurance, or have a family member that takes care of you, these services won’t be replaced by paid care through CHOICES. Instead, the home care you receive through CHOICES will work together with the assistance you already receive to help you stay in your home and community longer. Care in CHOICES will be provided as cost-effectively as possible so that more people who need care will be able to get help.

However, if you’ve been getting services through the State-funded Options program, you won’t qualify to get those services anymore. They’re for people who don’t get Medicaid. And if you’ve been getting services from programs funded by the Older Americans Act (like Meals on Wheels, homemaker, or the National Caregiver Family Support Programs) that you can now get through CHOICES, you’ll get the care you need through CHOICES.

If you want home care, the care coordinator will also assess risk. This will help to identify any additional risks you may face as a result of choosing to receive care at home. It will also help to identify ways to help reduce those risks and to help keep you safe and healthy.

To see if you qualify to enroll in CHOICES, call us at <phone number>.

Does someone you know that isn’t on TennCare want to apply for CHOICES? They should contact their local Area Agency on Aging and Disability (AAAD) for free at 866-836-6678. Their local AAAD will help them find out if they qualify for TennCare and CHOICES.

## E2. Who can qualify to enroll in CHOICES?

There are (3) groups of people who can qualify to enroll in CHOICES.

**CHOICES Group 1** is for people of all ages who receive nursing home care.

To be in CHOICES Group 1, you must:

* Need the level of care provided in a nursing home, **and**
* qualify for Medicaid long-term services and supports, **and**
* receive nursing home services that TennCare pays for.

TennCare Long-Term Services and Supports will decide if you need the level of care provided in a nursing home. TennCare Member Services will decide if you qualify for Medicaid long-term services and supports. We’ll help you fill out the papers TennCare needs to decide. What if TennCare says yes? If you’re receiving nursing home services that TennCare will pay for, TennCare will enroll you into CHOICES Group 1. If TennCare says you don’t qualify, you’ll get a letter that says why. It will say how to appeal if you think it’s a mistake.

**CHOICES Group 2** is for certain people who qualify for nursing home care but choose to receive home care instead. To be in CHOICES Group 2, you must:

* Need the level of care provided in a nursing home, **and**
* qualify for Medicaid long-term services and supports because you receive SSI payments OR because you’ll need and will receive home care services instead of nursing home care, **and**
* be an adult 65 years of age or older, **or**
* be an adult 21 years of age or older with a physical disability.

If you need home care services but don’t qualify in one of these groups, you can’t be in CHOICES Group 2, but you may qualify for other kinds of long-term services and supports.

TennCare Long-Term Services and Supports will decide if you need the level of care provided in a nursing home. TennCare Member Services will decide if you qualify for Medicaid long-term services and supports for one of the reasons listed above. We’ll help you fill out the papers they need to decide. If TennCare says yes, to enroll in CHOICES Group 2 and begin receiving home care services:

* We must be able to safely meet your needs at home.
* And the cost of your home care can’t be more than the cost of nursing home care. The cost of your home care includes any home health or private duty nursing care you may need.

If we can’t safely meet your needs at home, **or** if your care would cost more than nursing home care, you can’t be in CHOICES Group 2. But you may qualify for other kinds of long-term services and supports.

If TennCare says you don’t qualify, you’ll get a letter that says why. It will say how to appeal if you think it’s a mistake.

**CHOICES Group 3** is for certain people who **don’t qualify for nursing home care** but **need home care** to help them stay at home safely.

To be in CHOICES Group 3, you must:

* Be “at risk” of going into a nursing home unless you receive home care, **and**
* qualify for Medicaid long-term services and supports because you receive SSI payments OR because you’ll receive home care services instead of nursing home care[[1]](#footnote-2), **and**
* be an adult 65 years of age or older, **or**
* be an adult 21 years of age or older with a physical disability.

TennCare Long-Term Services and Supports will decide if you’re “at risk” of going into a nursing home. TennCare Member Services will decide if you qualify for Medicaid long-term services and supports for one of the reasons listed above. We’ll help you fill out the papers they need to decide.

If TennCare says yes, to enroll in CHOICES Group 3 and begin receiving home care services:

* We must be able to safely meet your needs at home with the care you’d get in CHOICES Group 3.
* If we can’t safely meet your needs with the care that you’d get in CHOICES Group 3, you can’t be in CHOICES Group 3. But TennCare may decide that you qualify for other kinds of long-term services and supports, including nursing home care.

## E3. Limits on Enrollment into CHOICES Group 2 and 3

Not everyone who qualifies to enroll in CHOICES Group 2 or Group 3 may be able to enroll. There’s an enrollment target for CHOICES Group 2 and Group 3. It’s like a limit on the number of people who can be in the group at one time. (The number of people who can enroll is sometimes called “slots”.) This helps to ensure that the program doesn’t grow faster than the State’s money to pay for home care. It also helps to ensure that there are enough home care providers to deliver needed services.

The enrollment target for the number of slots that can be filled in CHOICES Group 2 and Group 3 will be set by the state in TennCare Rules.

For CHOICES Group 2 it doesn’t apply to people moving out of a nursing home. And, it **may** not apply to some people who are on TennCare that would have to go into a nursing home right away if less costly home care isn’t available. We must decide if you would go into a nursing home right away and provide proof to TennCare. And we must show TennCare that there are home care providers ready to start giving you care at home.

Some slots will be held back (or reserved) for emergencies. This includes things like when a person is leaving the hospital and will be admitted to a nursing home if home care isn’t available. Reserved slots won’t be used until all the other slots have been filled. The number of reserved slots and the guidelines to qualify in one of those slots is in TennCare Rules. If the only slots left are reserved, you’ll have to meet the guidelines for reserved slots to enroll in CHOICES Group 2 or Group 3.

If you don’t meet the guidelines for reserved slots or there are no slots available and you qualify to enroll in CHOICES Group 2 or Group 3, your name will be placed on a waiting list. Or, if you meet the guidelines for CHOICES Group 2, you can choose to enroll in CHOICES Group 1 and receive nursing home care. There’s no limit on the number of people that can be enrolled in Group 1 and go into a nursing home. (But you don’t have to receive nursing home care unless you want to. You can wait for home care instead.)

People enrolled in CHOICES Group 2 above the enrollment target must get the first slots that open up. (These are people who have moved out of nursing homes or people already on TennCare and would have gone into a nursing home right away if less costly home care wasn’t available.)

When everyone in CHOICES Group 2 is under the enrollment target and there are still slots available, TennCare can enroll from the waiting list based on need.

## E4. Receiving Services in the CHOICES Program

The covered long-term services and supports you can receive in CHOICES depend on the CHOICES Group you’re enrolled in. If you enroll in CHOICES, TennCare will tell you which CHOICES Group you’re in. **There are three (3) CHOICES Groups.**

People in **CHOICES Group 1** receive nursing home care.

People in **CHOICES Group 2** need the level of care provided in a nursing home but receive home care (or HCBS) instead of nursing home care. Everyone in CHOICES Group 2 has an individual cost neutrality cap which is usually related to the average cost of nursing home care. This amount is updated every year.

People in **CHOICES Group 3** receive home care (or HCBS) to prevent or delay the need for nursing home care. There’s an $18,000 per year limit on services in CHOICES Group 3.

The kinds of home care covered in CHOICES Group 2 and Group 3 are included below. Some of these services have limits. This means that TennCare will pay for only a certain amount of these services. The kind and amount of care you get in CHOICES depends on your needs.

These services include:

**Personal care visits** (up to 2,580 hours per calendar year) - Someone will help you with personal care needs and support in the home, on the job, or in the community. Do you need this kind of personal care? If you do, the worker giving your personal care visits can also help with household chores like fixing meals, cleaning, or laundry. And they can run errands like grocery shopping or picking up your medicine.

* They can only help with those things for you, not for other family members who aren’t in CHOICES. And they can only do those things if there’s no one else that can do them for you.

**Home-delivered meals** (up to 1 meal per day).

**Personal Emergency Response System** - A call button so you can get help in an emergency when your caregiver isn’t around.

**Adult day care** (up to 2,080 hours per calendar year) - A place that provides supervised care and activities during the day.

**In-home respite care** (up to 216 hours per calendar year) - Someone to come and stay with you in your home for a short time so your caregiver can get some rest.

**In-patient respite care** (up to 9 days per calendar year) – A short stay in a nursing home or assisted care living facility so your caregiver can get some rest.

**Assistive technology** (up to $900 per calendar year) – Certain low-cost items or devices that help you do things easier or safer in your home like grabbers to reach things.

**Minor home modifications** (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) – Certain changes to your home that will help you get around easier and safer in your home like grab bars or a wheelchair ramp.

**Pest control** (up to 9 units per calendar year) - Spraying your home for bugs or mice.

**Assisted Care Living Facility** - A place you live that helps with personal care needs, homemaker services and taking your medicine. You must pay for your room and board.

**Critical Adult Care Home** – A home where you and no more than 4 other people live with a health care professional that takes care of special health and long-term care needs. (Under state law, available only for people who are ventilator dependent or who have traumatic brain injury. You must pay for your room and board.) Critical Adult Care Homes are available for Group 2 members ONLY.

**Companion Care** – Someone you hire who lives with you in your home to help with personal care or light housekeeping whenever you need it. (Available only for people in Consumer Direction who are in Group 2 and who need care off and on during the day and night that can’t be provided by unpaid caregivers. And only when it costs no more than other kinds of home care that would meet your needs.)

**Community Living Supports** (**CLS**) – A shared home or apartment where you and no more than 3 other people live. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation and other supports needed to remain in the community.

**Community Living Supports – Family Model** (**CLS-FM**) – A shared home or apartment where you and no more than 3 other people live with a trained host family. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation and other supports needed to remain in the community.

**Enabling technology is a new service** (up to $5,000 per calendar year) – Enabling technology is the use of various forms of devices and technology to support independent living such as sensors, mobile applications, remote support systems and other smart devices. Enabling Technology can support a person in navigating their jobs and communities, gain more control of their environment, and provide remote support and reminders to assist a person in independent living.

**Coverage decisions for Long-Term Services and Supports**

Sometimes you may have to ask us if we cover your medical care or behavioral health (mental health or substance use disorder) services before you receive them even if a doctor says you need the services. This is called a coverage decision. Please review **Chapter 9** for more information on what to do, if this occurs.

**Using Long-Term Services and Supports Providers Who Work with <plan name>**

Just like health care and behavioral health services, you must use providers who work with us for most long-term services and supports. You can find the *Provider Directory* online at <URL>. Or call us at <phone> to get a list. Providers may have signed up or dropped out after the list was printed. But the online *Provider Directory* is updated every week. You can also call us at <phone> to find out if a provider is in our network.

In most cases, you must receive services from a long-term services and supports provider on this list so that TennCare will pay for your long-term services and supports. However, there are times when TennCare will pay for you to get care from a long-term services and supports provider who doesn’t usually work with us. But, we must first say that it’s OK to use a long-term services and supports provider who doesn’t usually work with <plan name>.

# Behavioral health (mental health and substance use disorder) services

You **don’t** need to see your PCP before getting behavioral health services. But, you’ll need to get your care from someone who is in our network.

A Community Mental Health Agency (CMHA) is one place you can go for mental health or substance use disorder services. Most CMHAs take TennCare.

# How to get consumer directed care

## G1*.* What consumer directed care is

Consumer Direction is a way of getting some of the kinds of home care you need. It offers more choice and control over **who** gives your home care and **how** your care is given. In CHOICES, the services available through Consumer Direction are:

* personal care visits;
* in-home respite; **and**
* companion care (Only if you qualify for and are enrolled in CHOICES Group 2).

## G2. Who can get consumer directed care (for example, if it’s limited to waiver populations)

In Consumer Direction, you actually employ the people who give some of your home care services—they work **for you** (instead of a provider). You must be able to do the things that an employer would do. These include things like:

Hiring and training your workers

* Find, interview and hire workers to provide care for you.
* Define workers’ job duties.
* Develop a job description for your workers.
* Train workers to deliver your care based on your needs and preferences.

1. Setting and managing your workers’ schedule

* Set the schedule at which your workers will give your care.
* Make sure your workers clock in and out using an Electronic Visit Verification (EVV) system **every** time they work.
* Make sure your workers provide *only* as much care as you’re approved to receive.
* Make sure that no hourly worker gives you more than 40 hours of care in a week.

1. Supervising your workers

* Supervise your workers.
* Evaluate your workers’ job performance.
* Address problems or concerns with your workers’ performance.
* Fire a worker when needed.

1. Overseeing workers’ pay and service notes

* Decide how much your workers will be paid (within limits set by the state).
* Review the time your workers report to be sure it’s right.
* Ensure there are good notes kept in your home about the care your workers provide.

1. Having and using a back-up plan when needed

* Develop a back-up plan to address times that a scheduled worker doesn’t show up (you can’t decide to just go without services).
* Activate the back-up plan when needed.

## G3. How to get help in employing personal care providers (if applicable)

If you can’t do some or all of these things? Then you can choose a family member, friend, or someone close to you to do these things for you. It’s called a “Representative for Consumer Direction.” It’s important that you pick someone who knows you very well that you can depend on. To be your Representative for Consumer Direction, the person must:

* Be at least 18 years of age.
* Know you very well.
* Understand the kinds of care you need and how you want care to be given.
* Know your schedule and routine.
* Know your health care needs and the medicine you take.
* Be willing and able to do **all** of the things that are required to be in Consumer Direction.
* Live with you in your home **or** be present in your home often enough to supervise staff. This usually means at least part of every worker’s shift. But it may be less as long as it’s enough to be sure you’re getting the quality of care you need.
* Be willing to sign a Representative Agreement, saying they agree to do these things.

**Your Representative can’t get paid for doing these things.**

You or your Representative will have help doing some of the things you must do as an employer. The help will be provided by a Fiscal Employer Agent (also called FEA). There are 2 kinds of help you’ll receive:

1. The FEA will help you and your workers fill out all of the paperwork that you must complete. They’ll pay your workers for the care they give. And, they’ll fill out and file the payroll tax forms that you must fill out as an employer.
2. The FEA will hire or contract with a Supports Broker for you. A Supports Broker is a person who will help you with the other kinds of things you must do as an employer. These are things like:

* Writing job descriptions;
* Helping you and your workers with paperwork and training;
* Scheduling workers based on your support plan; **and**
* Developing an initial back-up plan to address times when a scheduled worker doesn’t show up.

**But,** your Supports Broker can’t help you supervise your workers. You or your Representative must be able to do that by yourself.

The kind and amount of care you’ll get depends on what you need. Those services are listed in your support plan. You won’t be able to get more services by choosing to be in Consumer Direction. You can only get the services you need that are listed in your support plan.

You can choose to get some of these services through Consumer Direction **and** get some home care from providers that work with your TennCare health plan. But, you must use providers that work with <MCO> for care that you can’t get through Consumer Direction.

**Can you pay a family member or friend to provide care in Consumer Direction? Yes, you can pay a family member, but you can’t:**

* Pay your spouse to provide care;
* Pay someone who lives with you to provide personal care or in-home respite services;
* Pay an immediate family member to provide Companion Care. An immediate family member is a spouse, parent, grandparent, child, grandchild, sibling, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, and son-in-law. Adopted and step members are included in this definition;
* Pay someone who lives with you now or in the last 5 years to provide Companion Care.

**And**, CHOICES can’t pay family members or others to provide care they would have given for free. CHOICES only pays for care to meet needs that **can’t** be met by family members or others who help you. The services you need are listed in your support plan.

If you’re in CHOICES and need services that can be consumer directed your care coordinator will talk with you about Consumer Direction. If you want to be in Consumer Direction, your care coordinator will work with you to decide which of the services you’ll direct and start the process to enroll you in Consumer Direction. Until Consumer Direction is set up, you’ll get the services that are in your support plan from a provider who works with <plan>, unless **you choose** to wait for your Consumer Directed workers to start. If you choose to wait for your Consumer Directed workers to start, you must have supports in place to give you the care you need.

You can decide to be in Consumer Direction at any time. If you’re directing one or more services and decide not to be in Consumer Direction anymore, you **won’t** stop getting long-term services and supports. You’ll still be in CHOICES. You’ll get the services you need from a provider who works with <plan> instead.

# Transportation services

If you don’t have a way to get to your health care visits, you may be able to get a ride from TennCare.

You can get help with a ride:

* **Only** for services covered by TennCare, **and**
* **Only** if you don’t have any other way to get there.

You can have someone ride with you to your appointment if:

* You’re a child under the age of 21 **or**
* You have a disability or need help to get the service (like someone to open doors for you, push your wheelchair, help you with reading or decision making).

Try to call **at least 72 hours before** your health care appointment to make sure that you can get a ride. If you change times or cancel your health care appointment, you must change or cancel your ride too.

[*Plans must explain who to call and how*.]

If you need a ride to your appointment or have questions about having someone ride with you, call us at <phone>**.**

# Covered services in a medical emergency, when urgently needed, or during a disaster

## I1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury, or a medical condition that’s quickly getting worse. The condition is so serious that, if it doesn’t get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

* serious risk to your life [*insert as applicable:* and, if you’re pregnant, loss of an unborn child]; **or**
* loss of or serious harm to bodily functions; **or**
* loss of a limb or function of a limb; **or**
* [*Insert as applicable:* In the case of a pregnant woman in active labor, when:
  + There isn’t enough time to safely transfer you to another hospital before delivery.
  + A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]

If you have a medical emergency:

* **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don’t**need approval or a referral from your PCP. You don’t need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories [*insert as applicable*: or worldwide], from any provider with an appropriate state license even if they’re not part of our network.
* [*Plans add if applicable:* **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or someone else [*plans can replace “someone else” with “your care coordinator” or other applicable term*] should call to tell us about your emergency care, usually within 48 hours. However, you won’t pay for emergency services if you delay telling us.] [*Plans must provide the contact phone number and days and hours of operation or explain where to find the information (e.g., on the back of the Member ID Card)*.]

**Covered services in a medical emergency**

[*Plans that cover emergency medical care outside the United States or its territories through Medicaid can describe this coverage based on the Medicaid program coverage area. Plans must also include language emphasizing that Medicare doesn’t provide coverage for emergency medical care outside the United States and its territories*.]

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They’ll continue to treat you and will contact us to make plans if you need follow-up care to get better.

[*Plans can add to this paragraph as needed to include other information about their post-stabilization care.*] Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we’ll try to get network providers to take over your care as soon as possible.

**Getting emergency care if it wasn’t an emergency**

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn’t really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

However, after the doctor says it wasn’t an emergency, we cover your additional care only if:

* You use a network provider **or**
* The additional care you get is considered “urgently needed care” and you follow the rules for getting it. Refer to the next section.

## I2. Urgently needed care

Urgently needed care is care you get for a situation that isn’t an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

**Urgently needed care in our plan’s service area**

In most cases, we cover urgently needed care only if:

* You get this care from a network provider **and**
* You follow the rules described in this chapter.

If it’s not possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.

[*Plans must insert instructions for how to access urgently needed services (e.g., using urgent care centers, a provider hotline, etc.)*.]

**Urgently needed care outside our plan’s service area**

When you’re outside our plan’s service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren’t considered urgently needed even if you’re outside our plan’s service area or our plan network is temporarily unavailable.

Show your <plan> card when you get the urgently needed care. Ask the provider to send the bill to <plan>. If the provider says no, ask if they’ll send the bill to you at home. Or if you have to pay for the care, get a receipt.

When you get home, call us and tell us you had to pay for your health care or that you have a bill for it. We’ll work with you and the provider to put in a claim for your care.

[*Insert if applicable: Plans with world-wide emergency/urgent coverage as a supplemental benefit*:Our plan covers worldwide [*Insert as applicable*: emergency and urgently needed care OR emergency OR urgently needed care] services outside the United States and its territories under the following circumstances [*insert details*.] *Otherwise, include the following paragraph:*

**IMPORTANT: TennCare and <plan> will only pay for emergencies away from home that are inside the United States and its territories**. We can’t pay for care you get out of the country.]

## I3. Care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the president of the United States declares a state of disaster or emergency in your geographic area, you’re still entitled to care from our plan.

Visit our website for information on how to get care you need during a declared disaster: <URL>. [*In accordance with 42 CFR 422.100(m), plans must include on their web page, at a minimum, information about coverage of benefits at non-contracted facilities at network cost-sharing without required PA; terms and conditions of payment for non-contracted providers; and each declared disaster’s start and end dates*.]

During a declared disaster, if you can’t use a network provider, you can get care from out-of-network providers at [*insert as applicable:* the in-network cost-sharing rate **or** no cost to you]*.* If you can’t use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Evidence of Coverage* for more information.

# What if you’re billed directly for covered services

[*Plans with an arrangement with the state can add language to reflect that the organization isn’t allowed to reimburse members for Medicaid-covered benefits.*]

[*Insert as applicable*: If you paid for your covered services **or** If you paid more than your plan cost-sharing for covered services] or if you got a bill for [*plans with cost-sharing, insert:* the full cost of] covered medical services, refer to **Chapter 7** of this *Evidence of Coverage*to find out what to do.

**You shouldn’t pay the bill yourself. If you do, we may not be able to pay you back.**

## J1. What to do if our plan doesn’t cover services

You won’t have to pay for services that are covered by Medicaid. If you choose to pay out of pocket for a covered service, you WON’T be reimbursed. Our plan covers all services:

* that are determined medically necessary, **and**
* that are listed in our plan’s Benefits Chart (refer to **Chapter 4** of this *Evidence of Coverage*), **and**
* that you get by following plan rules.

If you get services that our plan doesn’t cover, **you pay the full cost yourself**.

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we won’t pay for your services, you have the right to appeal our decision.

**Chapter 9** of this *Evidence of Coverage* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you’ve used.

# Coverage of health care services in a clinical research study

## K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you’re in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that’s not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don’t** need to tell us or get approval from us [*plans that don’t use PCPs can delete the rest of this sentence*] or your primary care provider. Providers that give you care as part of the study **don’t** need to be network providers. This doesn’t apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to a coverage decision and other plan rules.

**We encourage you to tell us before you take part in a clinical research study.**

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care coordinator to contact Member Services to let us know you’ll take part in a clinical trial.

## K2. Payment for services when you’re in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you’re covered for most services and items you get as part of the study. This includes:

* room and board for a hospital stay that Medicare would pay for even if you weren’t in a study
* an operation or other medical procedure that’s part of the research study
* treatment of any side effects and complications of the new care

[*Plans that conduct or cover clinical trials that aren’t approved by Medicare insert:* If you volunteer for a clinical research study, we pay any costs that Medicare doesn’t approve but that our plan approves.] If you’re part of a study that Medicare [*plans that conduct or cover clinical trials that aren’t approved by Medicare, insert:* or our plan]**hasn’t** approved, you pay any costs for being in the study.

## K3. More about clinical research studies

You can learn more about joining a clinical research study by reading “Medicare & Clinical Research Studies” on the Medicare website ([www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf](https://www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf)). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

# How your health care services are covered in a religious non-medical health care institution

Sometimes your provider can’t give you the care or treatment you need because of their conscience/ethical/moral or religious reasons. Call us at <phone>. We can help you find a provider who can give you the care or treatment you need.

## L1. Definition of a religious non-medical health care institution

[*If applicable, plans revise this section to describe Medicaid’s role in providing care in religious non-medical health care institutions*.]

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

## L2. Care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you’re against getting medical treatment that’s “non-excepted.”

* “Non-excepted” medical treatment is any care or treatment that’s **voluntary and not required** by any federal, state, or local law.
* “Excepted” medical treatment is any care or treatment that’s **not voluntary and is required** under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

* The facility providing the care must be certified by Medicare.
* Our plan only covers non-religious aspects of care.
* If you get services from this institution provided to you in a facility:
  + You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  + [*Omit this bullet if not applicable*] You must get approval from us before you’re admitted to the facility, or your stay **won’t** be covered.

[*Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Benefits Chart in Chapter 4 [insert reference, as applicable]) or whether there’s unlimited coverage for this benefit*.]

# Durable medical equipment (DME)

## M1. DME as a member of our plan

[*Plans can modify this section based on Medicaid coverage*.]

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you [*insert if the plan sometimes allows transfer of ownership to the member*: usually] **won’t** own the rented DME items, no matter how long you rent it.

[*If the plan allows transfer of ownership of certain DME items to members, the plan must modify this section to explain the conditions and when the member can own specified DME*.]

[*If the plan sometimes allows transfer of ownership to the member for DME items other than prosthetics, insert:* In some limited situations, we transfer ownership of the DME item to you. Call Member Services at the phone number at the bottom of the page for more information.]

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you **won’t** own the equipment.

## M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

You’ll have to make 13 payments in a row under Original Medicare, or you’ll have to make the number of payments in a row set by the MA plan, to own the DME item if:

* you didn’t become the owner of the DME item while you were in our plan, **and**
* you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don’t count toward the payments you need to make after leaving our plan**.

* You’ll have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
* There are no exceptions to this when you return to Original Medicare or an MA plan

## M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare we cover:

* rental of oxygen equipment
* delivery of oxygen and oxygen contents
* tubing and related accessories for the delivery of oxygen and oxygen contents
* maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it’s no longer medically necessary for you or if you leave our plan.

## M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**,your supplier must provide:

* oxygen equipment, supplies, and services for another 24 months
* oxygen equipment and supplies for up to 5 years if medically necessary

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

* Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
* A new 5-year period begins.
* You rent from a supplier for 36 months.
* Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
* A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

1. Effective October 1, 2022, 1,750 slots will be funded for people who don’t receive SSI payments but meet the Group 3 medical eligibility rules AND qualify for Medicaid long-term services and supports because they’ll need and receive home care services. [↑](#footnote-ref-2)